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"I'm Not an Addict. I'm a Recovering Addict": Clashing Discourse and Identity at an Addiction Research Clinic

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Disciplines
Anthropology

**“ ‘I’m not an addict. I’m a recovering addict’:
Clashing Discourses and Identity at an Addiction
Research Clinic”**

Anthropology Senior Honors Thesis

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“ ‘I’m not an addict. I’m a recovering addict’: Clashing Discourses and Identity at an Addiction
Research Clinic”

Introduction:

“Flaky”, “unreliable”, “highly unmotivated”: These are just a few of the many negative modifiers that have been used to describe the seemingly derelict cast of cocaine addicts that continuously pass through the doors of the Addiction Research Clinic (ARC). The ARC is an outpatient addiction research clinic that provides free drug and alcohol addiction treatment to those who qualify for its clinical trials. Funded mainly by grant money from the National Institute of Drug Abuse (NIDA) or pharmaceutical companies, the center runs clinical trials in hopes of identifying an effective psychopharmacotherapy for the treatment of drug addiction. Discourses, centered on patient motivations and compliance, are pervasive at the center. Care providers blame patients, behind their backs, of coming in to the center solely to receive money, rather than to get clean. They cite innumerable missed visits and dirty urines as “proof” of these supposed ulterior motives. However, is this what is really going on?

These stereotypes represent one of the many manifestations of tension that arise when the competing discourses, of the ‘criminalization/morality of the addict’ and the ‘addiction as a chronic brain disorder’, collide. Within the walls of the clinic there is the belief that “objective” science is the ultimate answer to identifying and treating addiction. This provides a sharp contrast to the popular Alcoholics Anonymous (AA) model of addiction that relies on personal strengths and belief in a higher power in order to “cure” addiction. Researchers at the center view addiction as a public health problem, and struggle against the puritanical beliefs of our society that see addiction not as psychiatric disorder, but as a moral failing. However, what

these researchers fail to see is that they themselves, and their clinic, are not free from the moralizing judgments of our society.

The majority of patients I spoke with had been through several different treatment programs before coming to the ARC. They had done inpatient programs and medical detoxifications, but the ARC was the first time they had been given medications specifically aimed at treating their addiction. It was a new experience for them, and one that they seemed appreciative of. The staff was supportive and pleasant, and they were given the freedom to come and go from the center as they pleased. However, while they appreciated this new approach to treatment and care, they too had difficulty maneuvering the moral defect vs. disease concept of addiction. Many did not even define addiction as a biological problem.

The sharp contrast in these two discourses becomes striking within the walls of the Addiction Research Center. The supposed “objectivity” of addiction science is pitted against the reigning cultural ideals that are held by the majority of patients and even some care providers. The clashing discourses between the ‘criminalization of the addict’ and ‘addiction as a brain disease’ within the clinic have a profound impact on the ways in which the care providers and the patients themselves define and identify addiction and the addict.

The discourse on motivation and compliance reveals the intersection of two differing cultural beliefs. This intersection exposes some inherent inconsistencies in the treatment model of the ARC. However, it also creates a fluid identity for the addict that allows patients to maneuver between these differing cultural beliefs. Some patients do not identify as addicts, others have modified definitions of addiction, and still others have fully embraced the disease model. By shaping and shifting their own perceptions of addiction and being an addict the patients can attempt to reconcile the clash between these cultural discourses.

- *Situated Knowledge*

Taking a cue from Donna Haraway's concept of situated knowledge, I would like to place my research interests into perspective¹ (Haraway 1991). As the daughter of an addiction psychiatrist I grew up with very different ideas about drugs and addiction than my peers. Having "the talk" (or maybe I should say "talks" as addiction was a popular topic in our house) with my parents about drugs consisted of an explanation of the science behind addiction and the presentation of case studies. Addicts weren't bad people like everyone said they were. As my Dad explained it to me, they were just very sick. So I grew up in many ways with a profound respect for the addicts that my Dad fought (and still fights) so hard to help.

So, when I came to college I wanted to work at the Treatment Research Center. There was a certain mystique to being able to work with my father, and I could finally meet the addicts whom my Dad had come to care for, and who were so elusive to me as a child. I wanted to help his patients as much as he did. However, I was a lowly work-study, and as such I was restricted to filing and data entry. Yet, those countless hours spent in back offices, and in front of filing cabinets, exposed me to another world. I befriended the twenty somethings who worked as research technicians. They had a very different way of speaking about the addicts coming into our center. I listened as the techs gossiped about patients, and complained about their lack of motivation to get clean. There was a constant discourse that focused on patients being solely interested in the petty cash that they were given in reimbursement for filling out assessments. Too soon I became jaded with the center, just as the majority of the technicians had become.

¹ "Situated knowledges require that the object of knowledge be pictured as an actor and agent, not a screen or ground or a resource, never finally as slave to the master that closes off the dialectic in his unique agency and authorship of 'objective' knowledge. ... Objectivity is not about dis-engagement, but about mutual *and* usually unequal structuring, about taking risks in a world where 'we' are permanently mortal, that is, not in 'final' control." (Haraway, 1991)

When I was finally presented with the opportunity to have patient contact I jumped at the chance. I began doing phone screens. I spoke with patients on the phone, who were interested in getting treatment. I asked them, what I thought were very personal questions, about their drug use and mental health. They were incredibly open and honest. I was surprised, because the patients that I talked with seemed desperate for help, or so they told me. These couldn't be the same patients that the techs were always talking about. Yet, these patients were one in the same. So, why the disconnect?

And so we come full circle. The patient contact that I have had at the ARC differs strikingly from the "war stories" that the techs love to share with each other. In doing my fieldwork I have had my own share of "flaky" patients and missed visits, but I find that I have never lost respect for these people. This thesis is my attempt, no matter how insignificant it may be, to help a population that has suffered as the result of social marginalization as the result of poverty and the criminalization of addiction.

- *Research Methods*

Data for this project was collected using traditional ethnographic field methods of participant observation and interviews. All interviews with patients and care providers (a blanket term I use to cover all staff members with patient contact) were conducted at the Treatment Research Center. Interviews were not recorded because I was granted an IRB exemption, but consent to interview was obtained from all informants. Extensive field notes were taken after every interview. All patient names, and some care provider names, have been changed to protect anonymity.

- *History of the Field*

The field of addiction research is a “science in its infancy” as one of my informants told me. The field is unique in that it represents one of the first multidisciplinary and collaborative clinical research teams (Campbell 2007). Indeed, this is still the case. In the clinic where I worked the PIs came from various backgrounds. Some were psychiatrists, others were psychologists, and others were neuroscientists. In the 1950s the field stood out for its belief that drug addiction was a public health problem. Few people were willing to listen, and the new treatment methods that the field proposed differed sharply from the widely accepted Minnesota Model or Alcoholics Anonymous. Drug addiction was still a moral dilemma for the majority of Americans, and as such, a purely biological disease model, like the one clinical addiction researchers were suggesting, was unacceptable. (Campbell 2007; White 1998)

Clinical research on opiate addictions began in the 1920s, monkeys were used to try and establish animal models for the mechanisms of addiction. However, the field of clinical addiction research, as we know it today, did not begin until the late 1930s. In 1935 the US government opened one of two pseudo prison-hospitals in Lexington, Kentucky. It was designed as a treatment hospital to quarantine addicts away from “urban temptations” (Campbell 2007). It pursued a research mandate until 1979, and for many years it was the only site in the US that tested drugs in humans in order to understand the neurophysiology of the addiction (Campbell 2007).

The narcotics farm, as the Lexington hospital was referred to, worked to rehabilitate their patients. This came into conflict with the government’s drug policy, which sought to criminalize the addicts and wanted them to receive moral therapy. Despite this, the Lexington clinic detoxified its patients and provided them with medical care that addressed all of their needs. The

center began running research trials recruiting the prisoners as subjects. The focus of the trials was to identify the biological bases for addiction. (Campbell 2007) The ethics of the research at Lexington have been questioned, however, this research established the bases for modern addiction research that is focused on the biological mechanisms of the disorder. (Campbell 2007)

In the late 1960s the field took another turn and began looking at behavioral pharmacology. Behavioral pharmacologists criticized research that did not take into account the environmental factors. In the 1970s the field formally began to be known as “substance abuse research” and funding started becoming reliable. Behavioral pharmacologists also began gaining political opportunities that allowed them access to defining drug policies and directing more research funds. (Campbell 2007)

Behavioral scientists and psychopharmacologists would eventually merge their interests and present a unified front in the addiction sciences. This was followed by another shift in research that occurred in the 1990s. President Bush called the 90s the decade of the brain and addiction science’s laboratory logics shifted to localize addiction in the brain (Campbell 2007). Neuroscience entered the field as legitimizing force. The results of these studies are helping scientists to redefine addiction.

However, the field itself is still changing and evolving. Today there is no unified voice among addiction researchers (Campbell 2007). At the Addiction Research Clinic, the PIs I spoke with often talked about the dissension that they themselves created in the field. There is no consensus on the correct way to run a clinical psychopharmaceutical trial. Many scientists take a reductionist approach and believe that no behavioral therapy should be provided, because then it cannot be determined if it was the medicine or the behavioral therapy that helped the addicts.

The ARC is set in its belief that addiction is a biopsychosocial problem, and they refuse not to provide their patients with some form of behavioral therapy. They also rejected NIDA's wishes to not confront dirty urines, because they believed that confrontation was a crucial part in helping addicts to get clean. In an interview with Nancy Campbell, the head of the ARC said that he had learned to "superimpose research on good treatment", which in many ways sums up the treatment research beliefs and practices of the ARC (Campbell 2007).

However, in adopting a biopsychosocial model of addictions researchers are acknowledging that addiction is not just a disease. "It's social meanings mark the presence of continued concerns with deviance or aberrant behavior that remain part of the cultural repository of ideas and images that underlie our assumptions about governance" (Campbell 2007). In an article published in 2004, Nora Volkow, the director of National Institute of Drug Abuse and her colleague look to new neuroimaging studies to highlight the past of addiction research and forecast the future:

"Drug addiction manifests as a compulsive drive to take a drug despite serious adverse consequences. This aberrant behavior has traditionally been viewed as bad "choices" made voluntarily by the addict. However, recent studies have shown that repeated drug use leads to long-lasting changes in the brain that undermine voluntary control. This, combined with new knowledge of how environmental, genetic, and developmental factors contribute to addiction, should bring about changes in our approach to the prevention and treatment of addiction."

(Volkow and Li 2004)

In addressing the voluntary nature of addiction, Volkow is acknowledging the moral values and beliefs that Americans are attributing to drug addiction. Thus reinforcing the clash of discourses between the morally deficient addict and the addict as a disease patient that has been characteristic of addiction sciences since its inception.

- *The “Objectivity” of Addiction Science*

I would argue that the science of addiction is not as objective as its scientists would like to believe. As is seen in Nora Volkow’s previous quote, the addiction sciences must constantly fight against moral stereotypes of addicts to argue their belief in addiction as disease. Indeed, there is a rich array of anthropological and sociological literature that highlights the subjectivities that are inherent in the creation of scientific knowledge. Yet, my greater point is that scientists themselves sometimes reinforce the social construction of the addict as a criminal. I point to recent *Scientific American* articles as evidence for my argument. In 2004, Eric Nestler, a molecular psychiatrist, published an article entitled *The Addicted Brain*. He writes:

“Addiction’s toll on *health and productivity* in the U.S. has been estimated at more than \$300 billion a year, making it one of the most serious problems facing society. Therapies that could correct aberrant, addictive reactions to rewarding stimuli—whether cocaine or cheesecake or the thrill of winning at blackjack—would provide an enormous benefit to society. Because emotional and social factors operate in addiction, we cannot expect medications to fully treat the syndrome of addiction. But we can hope that future therapies will dampen the intense biological forces—the dependence, the cravings— that drive addiction and will thereby make psychosocial interventions more effective in *helping to rebuild an addict’s body and mind.*” (Nestler and Malenka 2004) (Emphasis added).

In this quote he uses statistics and facts to perpetuate the American stereotype that characterizes addicts as unproductive members of society. What’s more is that he suggests that through a mix of biological and psychosocial treatments these unproductive miscreants can be “rebuilt” and transformed into productive, socially responsible citizens. In a more recent article, *Seeking the*

Connections: Alcoholism and our Genes, John Nurnberger M.D., Ph.D. writes, “Nobody gets to be alcohol-dependent without *making some poor choices*, but clearly some people are more sensitive to alcohol than others in the same set of circumstances, and scientists are working to identify the sources of that vulnerability” (Nurnberger, et al. 2007)(Emphasis added). Here Nurnberger contradicts what his colleagues have been trying to prove, that addiction is *not* a voluntary disorder (O'Brien and McLellan 1996). He not only walks the line between characterizing addiction as a voluntary or un-voluntary behavior, but he also places addiction within a moral framework. He suggests that addiction occurs when an individual makes a series of “poor” or immoral decisions. While these articles are only two out of hundreds of articles that are published every year, it is important to note that they were written and published for the general public. These scientists are in essence reinforcing American stereotypes at the same time that they are purporting to be espousing objective science.

This clash of discourses is omnipresent in the addiction sciences. This is not surprising considering the lack of unity among many of the scientists. There is dissent even among the field as to the best treatment modality or the next promising area research. That being said, it is also difficult to completely shut out the reigning societal views of the time.

Addiction: A Psychiatric Disorder

- *Cocaine*

Cocaine is a stimulant. It stimulates the central nervous system, which increases the activity of the brain and spinal cord. There have been two cocaine epidemics in America. The first occurred began in the 1880s and lasted until the 1920s (Goodman, et al. 2007). The second began in the 1980s, and it was this epidemic that created a surge of funding for addiction related research. Cocaine users experience intense craving when exposed to cocaine related cues, such

as the neighborhood where they use, cocaine, or related paraphernalia (O'Brien 2008). These cravings make relapse difficult to prevent, and is a focus of current treatment research.

- *“Chronic Brain Disease”*

The birth of the American disease concept of addiction dates back to 1784 when Benjamin Rush published his seminal pamphlet on alcoholism. Since then American physicians have constantly been redefining our notions of addiction and disease as more and more scientific knowledge is produced. The theoretical model of addiction is very similar to that of an infectious disease. It begins with the interaction of an agent, a host, and an environment (O'Brien 2008). The progression from abuse to addiction is determined by the interaction among these three elements. Clinical researchers believe that effective treatment modalities must address all three of these factors.

Today, addiction specialists characterize addiction as a “chronic brain disorder”. Although the theoretical model resembles an infectious disease, once an addiction has been established it is a chronic condition. For the researchers at the ARC, medical detoxification is not an effective treatment for addiction, because it does address the underlying disorder. This concept of chronicity is based on the biological evidence that pathways in the brain are changed as the result of addictive substances. These changes persist well after the patient has stopped all drug use. As such there is an ever-present chance for relapse. (O'Brien and McLellan 1996)

In validating the idea of addiction as a chronic disorder, scientists point to the treatment of other chronic diseases to highlight their point. Compliance and relapse are important when discussing chronic disorders. For example, diabetes patients must be compliant with their diet and insulin injections. If they do not comply with treatment they will most likely suffer a relapse of their disease and may be hospitalized. Addiction researchers point to relapse rates of other

chronic disorders as evidence that addiction is comparable. Relapse rates for diabetes, hypertension, and asthma fall within the 30% to 50% range. Treatment for addictions has about a 50% success rate, with success being defined as a 50% reduction in substance use. (Kampman 2009c)

While addiction scientists believe that addiction is a chronic brain disorder, they have had difficulty convincing other medical professionals that this is the case. Even if a primary care provider is convinced of the medical model of addiction they often refer the patient to AA, because they don't want to deal with it. One of the PIs spoke with me about primary care providers' unwillingness to help addicts. "He said that 'they don't want them' because addicts are hard to control and they are characterized as 'bad patients'." (Field Notes, 2-26-09) Again, even within the rest of the medical profession the reigning moral cultural ideals persist. Addicts now are not necessarily bad or immoral "people", but their inability to control their behavior and the severity of their illness causes them to be labeled as bad "patients".

- *Diagnosis*

Diagnosis of "psychoactive substance dependence" is based on a set of diagnostic criteria located in the DSM-IV, the handbook for psychiatrists.

**DSM IV Diagnostic Criteria
Psychoactive Substance Dependence**

1. Tolerance - It takes more to get high
2. Withdrawal Symptoms
3. Frequently use more than intended
4. Frequent attempts to cut down
5. Occupational or social problems
6. Spends a lot of time using
7. Use despite known negative consequences

(American Psychiatric Association. and American
Psychiatric Association. Task Force on DSM-IV. 1994)

Diagnosis requires that a patient meet at least three of the above listed criteria. The first two, tolerance and withdrawal, are based on the body's biological dependence on the substance. In the past the first two criteria were enough for a diagnosis, but that neglects the "loss of control" that is characteristic of addiction. Thus, a patient also must fit at least one of the criteria from #3 to #7, which are known as the "loss of control" criteria. (Kampman 2009c)

Treatment Modalities at the ARC

- *The BRENDA Model*

The ARC follows a biopsychosocial explanatory model to treat its patients. The biopsychosocial model states that psychiatric illnesses are composed of three different components: a biological component, a psychological component, and an environmental component (Kampman 2009c). Because relapse is an ever-present threat due to the chronic nature of the disease, treatment should be regarded as a long-term engagement. Additionally, relapse is not viewed as a failure of treatment. Rather, it is thought of as a manifestation of the disease. As a testament to the long-term nature of treatment, director of the ARC told me that he had some patients that he had been seeing for over twenty years. The BRENDA model is based on a biopsychosocial explanatory model and was developed to help create a collaborative approach to treatment that

The BRENDA Model

Biopsychosocial evaluation
Report to patient on assessment
Empathetic understanding of the patient's problem
Needs derived in collaboration with the patient
Direct advice given to the patient
Assess response to advice and adjust as necessary

- *The Minnesota Model*

The Minnesota Model is a treatment modality that incorporates Alcoholics Anonymous, Narcotics Anonymous, and other like-minded groups into their treatment programs. I present it here to provide a contrast to the biopsychosocial model. The majority of the addicts I spoke with had attended some form of an AA meeting, whether it have been AA or Narcotics Anonymous (NA).

Alcoholics Anonymous (AA) was started well before the Minnesota Model was fully established. However, the Minnesota Model is a more comprehensive and modern approach to addiction that situates AA at its center as the primary way of maintaining sobriety. This model identifies addiction as a “disease”. It promotes intensive medical detoxification followed by AA as the primary source of after care. (White 1998)

AA beliefs about addiction and recovery are rooted in a spiritual model. AA literature does not provide an etiology for addiction. Sobriety and long-term recovery is based on the ability to surrender oneself fully to a higher spiritual being. Fully submitting to the Twelve Step Program²

² The Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol – that our lives had become manageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn to our will and our lives over to the care of God *as we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being that the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. (White, 1998)

requires the participant to be willing to fully acculturate him/herself and to commit to the reconstruction of his or her lifestyle. (White 1998)

Center Structure and Hierarchy:

- *Staff Hierarchy*

There is a distinct staff hierarchy at the center. At the very bottom lie the work-studies. This was the position that I held while working at the ARC. Usually work-studies are in charge of filing and data entry and are not allowed patient interaction, but as I worked there for many years I was granted patient interaction in the form of phone screens and intake screenings. At the bottom of the care provider hierarchy are the Research Technicians (techs). These employees are usually recent college graduates who are looking to strengthen their resumes for graduate school by working in a clinical research setting. Slightly above the techs are project managers (PMs). Project managers are in charge of larger, more intensive studies. Techs and PMs are the primary contacts for patients. They are in charge of scheduling all of the patient's appointments and paying the patient at the end of each visit. Above the PMs are the Research Coordinators. Each PI has one coordinator who is in charge of handling the day-to-day business of all of a PI's studies. Each PI has at minimum two studies running at any one time. Research coordinators correspond with the IRB, write and edit protocols and consents, and manage the techs. Coordinators have almost no patient contact, but coordinators are usually hired from within so they have previously worked with patients and have an intimate knowledge of the studies they work on.

Nurses are an essential component to the center hierarchy. All patients see a nurse on a regular visit throughout their duration in the study. This is to ensure that they are physically fit

and not experiencing any adverse events. Nurses also often prescribe medications to help patients successfully detox. before starting a study. Patients and nurses often develop intimate relationships, especially if a nurse is administering some form of minimal therapy, which often occurs in the alcohol studies.

Therapists work one on one with their patients. In weekly sessions they use Cognitive Behavioral Therapy to help their patients to identify and control potential triggers and associated behaviors. The ARC does not offer group therapy as part of its treatment programs. Principal Investigators sit at the top of the hierarchy. They meet with patients and are responsible for the daily operations of the center.

The hierarchy of the center is crucial to in looking at the level of care that the patients are receiving and the messages they are being sent. The PIs, therapists, and nurses have all been working at the center many years. There is very little turnover among these positions. All of the PIs have been working at the ARC for fifteen plus years. As such, these care providers are highly invested in the beliefs of the center, and seem to be much more invested in the lives and treatment outcomes of their patients. The techs on the other hand tend to stay at the center for a period of about 2 years. Turnover rate among research technicians is very high. As such, these staff members are not highly invested in center's treatment goals or research aspirations.

This hierarchy of investment became obvious when I asked individuals to discuss their beliefs about the effectiveness of the treatment being offered. Techs were always quick to respond that they believed the treatments to be highly ineffective. As one tech put it, "Everyone is just looking for a pill to pop." Other techs had similar comments, and were always citing the reliance on medication as a downfall of the treatments. Another tech lamented that it was quite obvious to her that the medications were not working, because none of her patients ever got

clean. Thus, she reasoned that it wasn't necessary to go through the treatment with 200 patients to prove that the treatment wasn't working.

Therapists and PIs were more hopeful about the treatments. While poor study results were disappointing, they were looking forward to the next study and the next opportunity. Just as treatment is viewed as a long-term process, the research was deemed to be a long-term project. Also, because these staff members had had much more experience working with the addicts they were much more willing to forgive their sometimes erratic or unreliable behaviors. While the techs expressed frustration with these behaviors the older staff members merely saw it as part of the "disorder" of addiction, and thus it was not something that should be chastised harshly or even at all. Thus, as is seen through care provider attitudes, the level of acculturation and investment in the center's beliefs was manifested in discourse and sometimes in patient interactions.

- *General Research Practices*

All patients who are interested in coming to the ARC must call the center or stop by and complete and intake interview. At this interview, demographic data is collected as well as specific data regarding the patient's current drug use. Data such as last use, usual amount used, and number of days of use in the last 30 days is recorded for each substance. Known mental health problems are also noted. Patients who are currently diagnosed with Schizophrenia or Bipolar Disorder are not eligible for any trials at the center and are thus given referrals over the phone. If there appears to be no serious issues, the patient is scheduled for an intake visit.

The intake visit takes about 3 hours and patients are not compensated for their time, but they are given tokens so that they can return to the center. During this intake screening addicts meet with a nurse for a complete physical exam. They then meet with a trained therapist who

completes a psychosocial evaluation. At this point the patient is scheduled to come back later in the week at which point he or she may or may not be consented to participate in a study.

After the patient has attended an intake screening their case history is presented at the Intake Meeting. At this meeting the nurse and the therapist compare notes on the patient and present a clinical history to study staff. After this presentation different techs and coordinators jockey to claim the patient for their study. Some studies alternate days, so as to assure more equal access to the patient population. This can be crucial especially when “intakes are down” as was the case during my fieldwork.

Once a patient has been assigned to a study they are also assigned to a technician who will act as their contact for the duration of the study. Over the course of the study patients will come to the center between one and three times a week to complete study assessments or meet with any number of assorted care providers. Patients always provide a urine sample and are breathalyzed. Data cannot be collected if the patient’s BAC is too high.

In order to collect data on a patient’s drug and alcohol use the technicians are trained to administer a Time Line Follow Back. This is a semi-structured interview that is used to help establish past use patterns. If a patient cannot remember exactly how much he used or drank on a particular night the staff is trained to work with the patient to establish typical patterns of use or use key dates and events to trigger memories. For example, holidays such as the Fourth of July or Easter are specifically pointed out to patients because often clients will drink more on or around holidays. The staff also includes events that are pertinent to the patient, such as birthdays, when reconstructing previous use.

One of the unique protocols at the center is the belief in confronting dirty urines. This practice is not standard at other research clinics across the country. One PI I spoke with told me

that he thought the ARC might be the only center that did it. NIDA does not think that dirty urines should be confronted, because this could possibly bias the data. However, the director of the center does not agree with this and believes that confrontation is necessary to promote better clinical response. Confronting dirty urines allows the patient and his care providers to have a dialogue about his use and to reevaluate his treatment goals and achievements.

- *Clinical Trials*

I worked with patients from two different clinical trials. The first trial was a double blind, placebo-controlled study. It was testing two different medications for the treatment of cocaine dependence comorbid with alcoholism. This trial was actively recruiting while I was completing my fieldwork. The recruitment goal is estimated at around 200 participants. The trial was double-blinded so neither the patient nor any of his or her care providers knew if the pill packs they were receiving contained placebo or active medication. In addition to receiving medication all patients were receiving Cognitive Behavioral Therapy as part of their active treatment phase.

In terms of substance use there are several requirements that need to be met for an addict to participate. Patients must meet DSM-IV criteria for cocaine and alcohol dependence. Addicts must have used “no less than \$200 worth of cocaine in the past 30 days”. Patients must also have consumed 48 standard alcoholic drinks in a 30-day period within 90 days before intake as determined by the Timeline Follow Back. It also requires that addicts have 5 days of abstinence from cocaine and alcohol before being randomized. This period of abstinence is determined through urine tests and breathalyzers. (Kampman 2009a)

The second trial that I worked with was also double-blinded and placebo controlled. This was a study that was testing one pharmaceutical for the treatment of cocaine addiction. This trial was also actively recruiting during my fieldwork. Recruitment goals for this study were also aimed at

randomizing 200 patients. Like the first study this one was a double-blind placebo controlled trial.

Inclusion criteria for this study differed slightly from the first one. The expected abstinence period is only 2 days. Addicts must have used no less than \$200 of cocaine 30 days before intake. They also must have had 48 standard alcoholic drinks within a 30-day period as specified in the first criteria. (Kampman 2009b)

- *Demographics*

The studies at the ARC draw from very different patient populations depending on the primary substance dependence that is being treated. For example, those studies that focus primarily on the treatment of alcoholism tend to have a patient population that is characterized by middle class, middle aged white men. The majority are also suburban dwellers who drive into the city for weekly treatment visits. The ARC also has a satellite center in the town of Media that is only used for patients in our alcohol studies.

In contrast, the cocaine studies draw from a very different population. The patients that are randomized into the cocaine studies are primarily African American and come from the city of Philadelphia. These patients often live in poverty. Of the patients that I spoke to for this project almost all were unemployed or worked in construction, but did not have steady employment. At least half of the men I talked with were living out of shelters. Additionally, the majority of patients I spoke with had no medical insurance. The demographics of my informants are consistent with the larger patient population that our center serves.

The Criminalization of Addiction:

Addicts have long been criminalized for their behavior. In this section I review the literature that reveals and explores this history of criminalization and how it has socially marginalized this

specific population. I also want to highlight how the science of addiction has not been able to separate itself from popular societal and cultural beliefs about addiction. Finally, I want to show how the discourse on petty cash and patient motivations that pervades the ARC is in effect allowing these stereotypes to be perpetuated among its own care providers, despite its purported scientific objectivity.

- *The Criminal Addict*

As the historian David Courtwright says, “What we think about addiction very much depends on who is addicted” (Courtwright 2001). For example, the specific images of cocaine addicts as violent criminals began to form around the turn of the century, and were influenced by race.

“Violent cocaine fiends, however, appear to have been a more terrifying social fiction than an empirical reality and one with a sharp racial overtone. Especially in the racially tense South, but also in the cities of the North, such fears flourished and shaped the prevalent image of the cocaine user as an unpredictable menace to social order.” (Spillane 2000)

The idea of the addict as a threat to social order perpetuated the stereotypes of the early half of the 20th century. As the stereotypes changed and shifted over the years the racial overtones of drug use were maintained and applied to other ethnic minorities. Also, poverty and social standing would also come to play a significant role in the reigning cultural ideas of drug addiction.

Changing perceptions of drug use and addiction have greatly impacted societal views about treatment modalities. Today’s criminalization discourse finds its roots in the 1914 passage of the Harrison Act. This law criminalized the dispensing of narcotics (White 1998). As a result, there was a social transformation of the addicted population. Physicians began to fear prescribing opiates for their patients. Physicians knew little about addiction or how to treat it, and thus

medical professionals entered a time of sanctioned ignorance (Campbell 2007). Legal prohibition caused once “legitimate” substances and medicines to become “illegitimate” based on concerns that were influenced by the fear of and prejudice against their users who were deemed to be deviant and dangerous (Spillane 2000).

Caroline Acker reiterates Courtwright’s ideas in her exploration of the rise of the modern social concept of the “American junkie”. She, too, suggests that the meaning of drug use is crucially dependent of the social and cultural setting of use (Acker 2002). The prohibition movement and the, more recent, “war on drugs” have significantly shaped the way Americans perceive and identify drug users. By the 1980s responses to drug use were broken down into two categories. Drug users among the poor, unemployed, uneducated, uninsured, and ethnic minorities were subject to arrest or incarceration. On the other hand, white middle class users were less likely to receive legal sanctions, and there were more available support networks. (Acker 2002) The concept of the American junkie was shifting, and being more forcefully located among the poor and indigent.

Today’s societal construct of the addict identifies and locates the illegal substance user among the poor and socially unproductive members of society. In a society that values independence and productivity, poor drug addicts many times cannot contribute as they are accepted to. American society chooses to neglect the structural violence that is holding this marginalized population back and instead blames their troubles on their drug use.

These social disparities have perpetuated drug use among the poor. In Philippe Bourgois’ ethnography, *In Search of Respect*, he shows how the political economic factors perpetuate the illegal drug market through drug addicts’ desire to escape social marginalization (Bourgois 2003). They embrace the social stereotype and their positions as drug dealers, because it

empowers them and gives them a sense of agency. In *Drugging the Poor*, Merrill Singer argues that structural violence forces the poor to turn to drugs a means of self medication and escape from their hardships, but this, in turn, maintains the social order that has been put in place (Singer 2008). What is evident is that this criminalization has severely hurt and repressed the socially marginalized.

A quick perusal of Time Magazine articles on addictions highlights how this criminalization is perpetuated in popular culture. In a 1981 article on the rise of cocaine in the middle classes the author writes:

“Smuggling, murder, corruption, vast sums of money—all are deeply corrosive byproducts of the cocaining of America. So too are the physical shocks, the attrition of nerves, of health, of whole years of potentially productive life. Part of the underground economy of cocaine must be calculated in vast negative numbers: labor undone, careers sidetracked, money diverted from worthy projects.” (Demarest, et al. 1981)

While highlighting the new epidemic of cocaine use among the upper middle class Demarest points to the criminal activities surrounding the underground cocaine market to warn his readers that cocaine is not merely a leisure drug, but one that can be physically addicting and destructive. Again we see the repetition of the great American fear of unproductive citizens.

More recent articles that focus on the biological advancements of addiction treatment do little to change American cultural beliefs. In a U.S, News and World Report article on the new cocaine vaccine research the author continually refers to the technology as “vice vaccines”. “So while the current vaccines can't guarantee clean living, they might just represent a step toward a future when people end up as slaves to virtue, rather than vice” (Boyce 2003). An article in the Economist pointed to the rapid increase in drug law violations in small towns as evidence to the

growing crack use among rural adolescents. The article states “It calls for a similar investment at home in drug prevention, drug treatment and law enforcement, particularly in rural areas that have all the problems of big cities but less money to deal with them”(2000). These articles show how the disease model of addiction is having little effect in changing American cultural beliefs about the nature of addiction and the addicts themselves. In the face of larger political forces that mandate a “war on drugs”, and saturate the judicial system with drug law violations, the picture of the addict as a victim of his biology is doing little to change societal stereotypes and government policies.

- *Motivation/Compliance Discourse*

“He might talk to you, because he is not here for the money.” “She’s flaky, and you’re not paying her so I’m not sure she’ll talk to you.” “You should talk to Mark. He’s definitely not here for the money.” These are just a few examples of the conversations I had with the techs when trying to schedule patient interviews. I asked the techs to introduce me to some their patients. Every time I would stop by their office they would analyze their schedules for the day. Muttering, they would point to the screen, and tell me why I should, or shouldn’t, talk to a certain patient. There was always hesitation, and usually they would characterize their patients as “unreliable” or one of many other synonyms. This was then usually followed by an offhand comment about how it would be difficult for me to recruit people to talk to, because I couldn’t pay them. In reality, the most difficult part of recruiting patients was getting the techs to help me. If I wasn’t standing over their shoulders asking for patients, it was nearly impossible to meet new clients. The younger staff members were clearly frustrated by what they deemed to be a flaw in the overall functioning of the center, which came through in their countless complaints and conversations on the topic.

The discourse on patient motivations is prevalent not only among the younger staff members, but also more senior staff members such as the therapists and nurses. However, it should also be mentioned that the discourse is much stronger among the younger staff. One therapist I spoke with told me that she thought it was a minor problem and occurred much less than people thought it did. "I think it's a very small percentage. Sometimes we get one and then we'll have a rash because they tell their buddies." (Field Notes, 3-9-09) Yet she did believe it was occurring. When I asked her if this frustrated her she immediately responded no. She told me that it wasn't her job to get frustrated. The director of the center also reiterated the discourse when he told me that the petty cash system was a "necessary evil". He suggests that it not only attracts patients interested in treatment

However, when I finally sat down with the patients all of them expressed a sincere interest in becoming clean, or at the very least reducing their drug use. When I probed them about the petty cash some chuckled at me. Most agreed that the \$5 a visit they received was not enough money to make any sort of a difference. As one patient told me, "I spend more on my addiction than they give me here."

I had one patient who told me up front that he came for the money. Mark was an elderly patient and was living out of a shelter. His story is typical of many of the addicts that come through our center. He was unemployed and had no insurance. He had been through several other treatment programs before. Yet, while Mark told me that he came for the money, he was highly reliable and compliant with treatment. I complimented him on not having missed a visit and he told me that it was because it was something to do and it broke up his day. For Mark, as for many other patients, coming to the center multiple times a week is an opportunity to get off the streets, and to do something productive for a few hours. As another patient told me: "He said

that he likes coming to the center because it means that he is not on the street using and instead he is here talking to me.” (Field Notes, 3-20-09)

In looking at the conversations with the research technicians I can see the criminalization of addicts seeping into the center. In accusing this population of only wanting money the techs are, in essence, accusing the addicts of hustling the system. They have countless stories about patients who have screamed and caused scenes in the lobby, because they couldn’t pay them³.

From my field notes:

“They also shared many stories of people who were confused about how much they would be getting paid and then getting angry when they learned the facts. They also talked about how some patients don’t actually fill in the assessments. Calvin said he had one guy who would do the assessment wrong every time, because he would try to fill in the same number for every answer.” (4-16-09)

In the minds of the research technicians these addicts are taking advantage of the generosity of the center. They have difficulty reconciling the idea that these people are ill with what they deem to be “stealing”. They fail to see the other side of the story, in which their patient is off the street for an hour or so, and is in the company of supportive care providers.

The criminalization discourse goes beyond the comments on petty cash. The techs also constantly talked about how their patients lie to them and don’t comply with treatment. “Sarah sarcastically joked that everyone in their families has died, because many of the patients use death in the family as reasons for missed visits.” (Field Notes, 4-16-09) Similar stories often revolve around the comical stories that the addicts create to excuse their absences. The techs are

³ Sometimes addicts are not eligible to receive money for a visit, because they do not show up on their scheduled date. If they do not reschedule in a timely fashion, or if they show up unannounced they may be “out of window”. If a patient is “out of window” they usually meet with the nurse and the technician, but they cannot fill out assessments for the “missed” visit because too much time has passed. Thus, they are not eligible to receive any money.

frustrated not only by the obvious falsehoods, but also by the patient's unreliability. Yet, here again there is a failure to accept the medical discourse on addiction. Whereas the PIs and therapists would see the missed visits as a manifestation of the illness of addiction, the techs see it as "bad" behavior. They attribute the lies and "irresponsible" behavior to the moral character of the patient.

The younger staff members' strong opinions on patient compliance have led them to inadvertently label their patients as "good" or "bad" based on their perceived motivation and compliance. They are applying moral labels to behavior that is supposed to be a symptom of a psychiatric disorder. But, this also highlights the lack of acculturation that the techs have had. The majority of them have had no previous experience working with drug addicts, nor have they had previous knowledge of psychopharmacotherapies for drug addiction. Thus, they allow the moral and criminalizing social ideas that have influenced them all their lives to clash with the dominant scientific discourse of the clinic. They express this resulting tension in their characterizations of good vs. bad patients and the negative discourse on patient motivations for treatment.

Creating and Shaping Identities

The language in addiction research is never uniform, as is seen in the numerous words used to describe the people that come in for treatment: patient, client, and addict. Addict and addiction seems to be a fluid term that is constantly changing as the patients navigate through treatment, and try to reconcile their past experiences with those of the clinic. Their identity shifts and changes to accommodate new knowledge, or the culture in which they are situated. Identifying oneself as an addict can be very difficult for an individual, especially when we live in a culture that socially stigmatizes addicts. Thus, a fluid identity allows the addict to reduce

stigma and gain access to necessary resources. By negating the “addict” identity the patient tries to fit better within his or her own communities. By accepting themselves as a patient with a psychiatric disorder they can gain full access to the clinic and its resources.

We can also see how the clash of discourses affects these patients’ identities. Many of them come to the center without any or very little understanding of a disease model of addiction. They are often surprised at the positive and welcoming treatment that they receive when they first come in. As they are introduced to the center they are taught this disease model of addiction. However, this model does always fit within greater social and cultural forces that shape their lives. As a result, the patients adapt their identity to fit within the correct context.

- *Creating “an addict” within the ARC (Care Provider Perspective)*

One of the defining characteristics of addiction is the “loss of control”. It is this loss of control that the physicians and care providers at the ARC are trying desperately to restrain. The DSM IV diagnosis of psychoactive substance dependence is one of the main ways in which care providers can exert control over the disorder. By fitting a patient within to a certain set of criteria, and giving them the official scientific identity of an “addict” they are able to manifest what little control they have over the disorder.

Care providers at the TRC also “create” addicts through the intake process. Many addicts also suffer from other comorbid addictions or psychiatric disorders (O'Brien and McLellan 1996). However, the clinical trials have certain inclusion criteria that dictate who is eligible and who is not eligible for a study. Thus, the addicts, who are treated at the clinic, are in many ways socially created. The eligibility criteria allow the PIs to control which types of addicts are admitted to their study.

This control over patient identity extends even further. The clinic has released research showing that patients who can have a clean urine on day of intake and at the beginning of a study have better treatment outcomes (Kampman, et al. 2001). Thus, the studies I worked with required patients to stay clean for a minimum of three to five days depending on the study. The researchers are further narrowing down the acceptable addict for their studies. They are creating a sample of patients whose identities are all very similar. Through study requirements the researchers are attempting to further control what few aspects of the disorder that they can. By creating a more defined addict identity the clinic is aiming to produce better treatment results.

A further mention of the fluidity of the definition of addict can be seen from my discussions with the PIs about the future of the field. They all suggested that the future lies in further narrowing the diagnoses of addiction by creating subtypes of addicts. In one conversation the director of the center focused on the importance of genetic variation. "Dr. O'Brien elaborated on this identification of the subtypes of alcoholics as the future of addiction research. He believes that by identifying the genetics of all addicts it will be possible to uncover certain variations." (Interview with Director, 2-3-09) In a different interview another PI also discussed a similar idea. He believes that by focusing on different subpopulations he will be better able to treat his patients. By subpopulations this PI was referring to groups of addicts who were defined by their motivation for treatment. He determined treatment motivation by their ability and willingness to produce clean urines.

Thus, researchers are attempting to create new categories and patient identities in order to provide better treatment. Yet, at the same time, these new subpopulations suggest that researchers are further identifying "good" vs. "bad" patients. In the treatment motivated subpopulations of the one PI he is inherently suggesting that some patients are better or easier to

treat. What does this mean for future those addicts who addiction is much more severe than there counterparts? Isn't separating patients based on motivation reflexive of the subjective morality based discourse that these scientists are avoiding? Yes, behavior modification is an important part of treatment modalities. However, by identifying addicts based on their motivation in an attempt to control a "loss of control", it seems as if the morality vs. science discourse is manifesting itself once again.

- *Identifying Addiction or the Addict*

I received varying responses when I asked the addicts to define what an addiction is. Some responded using vague modifiers such as "it is a loss of control". Others told me that they were self medicating. Those who expressed a strong understanding of the biomedical model of addiction were those who had been through numerous inpatient treatment programs. For others, their vague "loss of control" definitions focused on their guilt for not being able to control something they knew was bad. In an interview this is how one patient described it to me: "He told me that [addiction] is when you like something so much that you continue to o it although you know its hurting you. He said he was constantly trying to rationalize the behavior."

(Interview with Moses, 3-20-09) Here again we see that those patients who did not fully understand the disease model of addiction thus identify their addiction as moral failing.

In the title of this paper I have included a quote from one of my informants. When I asked him if he considered himself an addict he quickly interjected and said, "I'm not an addict. I'm a recovering addict". His response was not unique. Another informant told me that he was different, because he was a "functional addict". They both redefined the term addict to show their moral or self worth. By specifying that he is a recovering addicting the one patient was making sure that I noted that he was a changed man. He had made a change in his life and he was

on the way up. The other patient I spoke with defined himself as a “functional addict”. He clarified by telling me that he was functional because he could keep a roof over his head and support himself. He was defining his place a socially responsible member of society. Their responses highlight the strength of the moral discourse of addiction on how addicts identify their disease.

The various responses to the question, What is addiction?, highlight the clash of discourses that permeates the clinic. Even though the patients were in an environment that viewed their addiction as a psychiatric disorder they still defined addiction within the context of a criminalization of addiction. The addictive behavior was “bad”, and they felt guilty for their inability to control it. On the other hand, those patients who had a fuller understanding of the disease model spoke of medicating themselves or having a mental illness.

- *Refusal to Self-Identify as an Addict*

What many of the care providers fail to fully comprehend is the true nature of the environment that their patients are living in. Many of my patients told me that drugs and alcohol were the only things to do in their neighborhood. Accepting the identity of an addict can be difficult for many of these patients. Yet, in order to be properly motivated and ready for treatment the patient must accept that he or she has a “problem”, and is willing to do something about it. Furthermore, the biopsychosocial model addresses not only biological and psychological aspects of addiction, but it also addresses environmental factors.

One PI told me that he tells his patients that it would be best for them to avoid old places and friends that are associated with their drug use. But, when your entire social and cultural network is embroiled in poverty and drug use is this really a possibility? Is it fair, or even effective, to ask

a patient to socially isolate himself? I believe that it is these issues, mixed with the clashing discourses on morality and disease, which cause many patients to refuse to identify as “addicts”.

Other patients that I talked with readily accepted that they were addicts, but when I questioned them if they had told any of their acquaintances that they were coming in for treatment they often said no. From my field notes:

“I met with Chris today. He is one of the youngest patients I have talked to. He is in his late twenties to early thirties. He said that his primary motivation for coming to the center was to get control over alcohol. His friends and family don’t know that he comes in for treatment. He seemed oddly proud of this. He told me that his girlfriend was sitting out in the lobby and even she didn’t know. ... He talked about how alcohol and cocaine are the only things to do in his neighborhood. If he told his friends that he was in treatment they would be ‘haters’ and not supportive. They would think that he was trying to be better than them.”

(Interview with Chris, 2-4-09)

Chris’s story is typical of the others who refused to identify themselves as a patient of the ARC among their friends and family. The patients told me that they were addicts and admitted to having a problem, but they usually did not tell anyone else that they were coming in. By identifying as an addict who is receiving treatment outside of the clinic is socially stigmatizing for many of the patients. They live in culture where drugs and drug addiction are ubiquitous. Thus, like Chris says, seeking treatment suggests that they think that they are better than their peers. These patients could willingly switch between their identities to accommodate whichever social circle they found themselves in.

- *Addicts as “Biological Citizens”*

By accepting the biological disease model of addiction, the patients are also creating a new identity for themselves.

In her ethnography, *Life Exposed*, Adriana Petryna presents us with the idea of “biological citizenship”. Through the experiences of the victims of the Chernobyl disaster, she shows us how these people are employing biological concepts to modify ideas of personhood and the body, in order to gain access to the resources and rights that are granted to full citizens. The biology of this population has become the basis for social status and citizenship.

“One can describe biological citizenship as a massive demand for but selective access to a form of social welfare based on a medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it. Such demands are also being formulated into the context of fundamental losses ...”(Petryna 2002)

In much the same way as the Chernobyl victims, the addicts the cocaine addicts at the Treatment Research Center are redefining their experiences to fit a biological model of personhood. By redefining their social and physical suffering within the biological definition of addiction these patients can gain “citizenship” within the clinic, and are privy to a higher level of care that has not been previously available to them.

As was the case with the Chernobyl disaster victims, addicts at our center must seek out the correct knowledge, and situate themselves within the esoteric. By redefining their addiction and their brains within a biological context they not only create a new identity, but they also accept citizenship within this treatment community. Those addicts that I have spoken with, and who understand the biological model of addiction, are much more invested in their treatment and have greater rapport with their care providers. This relationship goes both ways. The physicians

at the center have told me that they cannot help those patients who refuse to admit that they are sick. However, for many of these patients this biological model of addiction is a completely foreign concept. Some will never invest the time to educate themselves nor change their self-perceptions of addiction. While these patients are not denied treatment they tend to drop out or never stop using while in treatment. Additionally, addicts are admitted to our center based on their other biological traits. Patients suffering from other mental illnesses or serious physical health problems are referred out. As a result, patients try to manipulate the system by learning the exclusion criteria and lying about their medical histories to gain "citizenship".

This biological reductionism of the person, and the disease, is even more clearly evidenced by the daily intake meetings. At these meetings all new patients that were evaluated in the 24 hours before "intake" are presented for inclusion into the studies. For many of these patients 40 plus years of life experiences are compounded into a clinical presentation that lasts less than 5 minutes. Research coordinators often bicker over patients, and sometimes studies refuse, or attempt to refuse, patients that do not fit the inclusion criteria to a tee. I was often taken aback at the staff's ability to strip these patients of their personhood. It often felt like they were mere biological specimens rather than real people who were suffering in more ways than one.

As is witnessed in the intake meetings, the patients are commoditized. They are presented to the rest of the staff as a series of biological symptoms. Their illness becomes an entity that is desired by different studies. Once they have been presented staff members barter among themselves to claim the patient as his or her own. If the patient is biologically acceptable then they are granted access to the center and paid for their services, which in this case is further access to their illness and its symptoms. Thus, for the addicts their illness becomes equivalent to work or employment. As social scientists have shown, urban crack users represent a

marginalized population. Because the majority of these users are unable to maintain steady employment, they are available to be employed in low wage temp jobs. However, by identifying as a “biological citizen” the cocaine addicts at the center are transforming their illness into a new form of employment. One of the research technicians I spoke with told me that she found that her “money motivated” patients were her most reliable patients. I think that we can reframe her perception of patient motivation by placing it within the context of the “biological citizenship”. These patients are not primarily motivated to seek treatment at the ARC for monetary gain. As evidenced by their responses to my questions in the interviews these people have a true desire to end their addictions. However, in order to gain access to the center, and its treatment, they must redefine their concept of their disease. In doing so they are granted “citizenship” to a community where their disease becomes a valid means of income.

Biological citizenship within the field of addiction research refers to an addict’s ability to identify himself/herself as a patient who suffers from a chronic disease. By accepting this biological identity the addict becomes privy to a host of treatment options that were previously unavailable. Today, the biopsychosocial model of addiction is being used to provide the most scientifically effective treatment. However, because this model has not fully moved from the esoteric to the exoteric it’s access is limited to those patients who have become “citizens”⁴.

Conclusion:

The addiction sciences is still a very young field that has a long ways to go in bridging the gap between the belief in addiction as a chronic brain disorder and the prevailing social ideal

⁴ I would like to acknowledge that access to the clinic is also affected by a host of other factors. For example, if this treatment modality is the most effective, then why are government funds being used to establish methadone clinics that only promote the replacement of heroine addiction with a methadone addiction? Methadone clinics are the largest federally controlled treatment modality in the US (Bourgois, 2000). Some argue that NIDA is bowing down to a larger political agenda, but Nora Volkow has denied this accusation (Pearson, 2004). Thus, there are greater political economic factors that are acting as a barrier to treatment, but an in depth discussion of these factors is outside the scope of this paper.

that addiction is a moral failure. While the field purports to base all of its treatments on evidence from clinical trials, this does not mean that the field is free from the marginalizing social beliefs of the larger American public. Indeed, this belief in the addict as a criminal has permeated the walls of the Addiction Research Clinic.

This criminalization discourse is clearly evident in the constant conversations about patient motivations and compliance. The young research techs have not fully acculturated the addiction as a disease model, and thus they express frustration over their patients' behaviors, by criminalizing these behaviors.

However, it is also interesting to note how this clash between discourses plays out in the identities that the researchers create for their patients, and that the patients create for themselves. Researchers search for ways to weed out the unmotivated patients. In suggesting that some patients are better than others they are inherently suggesting that this motivation for treatment is in some ways morally superior to their counterparts. Yet, what these researchers often fail to understand is that their patients cannot self identify as an addict seeking treatment, because this could possible lead to social stigma.

The criminalization of the addict is one of the greatest obstacles that the addiction sciences face in promoting its psychopharmacotherapy of the chronic brain disorder of addiction. It often prevents both their own staff, and their patients from fully accepting the disease model of addiction. The field needs to look to ethnographic research to fully understand the cultural and environmental influences that are affecting the population it is treating. As was noted, the majority of the patients that the ARC serves live in urban poverty. As a result of social marginalization and structural violence these patients are held down in an abusive cycle drug abuse. While the addiction as a chronic disease model can help to change the social stigma

surrounding addictions, the scientists should not neglect the greater cultural and environmental factors that influence addiction, and influence the treatment they provide.

**A Note from the Author*

In writing this paper my goal was not to diminish the work that is being done at the ARC. Rather, I want to point out the inconsistencies that are occurring in hopes that changes can be implemented. So often in Medical Anthropology I find that we, as anthropologists, are drawn to criticizing the medical profession for its nearsightedness. That is not to say that our medical system is not flawed. It is (!), and I salute those people that have made it their work to point out the injustices that are inherent in this system. How can we bring about change if we first do not fully recognize that which is hurting us or bringing us down? Regardless, I would like to commend the nurses, therapists, and physicians that work at the ARC. Their unceasing compassion and care for this difficult patient population is refreshing, especially in a society that willingly casts addicts aside as useless and unproductive persons.

My original goal in starting this research project was to investigate the negative discourses that I had heard so often, and that I felt were in many ways harming the patients. While I heard an unceasing critical dialogue centered on patient motivations, I was also privy to countless conversations between patients and care providers. The following citations are taken from my field notes:

-“I turn the conversation back to the ARC and ask her to share her experiences with me.

She says that it is different because everyone is “warm, open, and accepting”. She likes that they don’t kick you out if you are not clean especially because she recalls not having one clean urine during the first study she was involved in.” (Interview with Lidia, 3-9-09)

- “He said that he keeps coming back in part because everyone is very nice to him. ...

[H]e was very forthcoming about how he enjoyed the staff. When we were finishing up he finally started talking a little more, and he shared that he thought he might keep coming back in to the center just to visit people after his treatment was finished.”

(Interview with David, 3-4-09)

-“At this point we are interrupted by a phone call. He immediately answers it, and by his reaction and the tone of his voice I can tell that it is a patient. He keeps telling the patient that he needs to find a doctor. It becomes clear that the patient has tried other doctors, but they are too expensive and he cannot afford it. After a few more minutes of back and forth, [Dr. K] interrupts the patient and tells him to come in with (he names a female) on Thursday. When he hangs up the phone I confirm that it is a patient. I assume that it is a private practice patient, but he says no it is a husband and wife who are both addicts. They were previously in a clinical trial at the center and she had to drop out because she became pregnant. I ask him if that means he is just going to treat them for free. He sighs and says yes “probably for the rest of my life.” (Interview with Dr.

K, 2-24-09)

Power, politics, and prejudices are an inevitable part of our society. The researchers at the Addiction Research Center believe strongly that addiction is a public health issue, but they face opposition from all of these forces. While the science is not entirely free from subjectivities, as it believes it is, addiction researchers work to try and improve treatments so as to better improve the lives of their patients. Their unwavering belief in the value and social importance of their work is laudable.

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